LAWRENCE REPSHER, M.D.
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July 10, 2006

Jeffery Ubersax
JonesDay
901 Lakeside Avenue
Cleveland, OH 44114-1190

RE: Suzanne Genereux
VS: American Beryllia, et al.

Dear Mr. Ubersax:

Ms. Suzanne Genereux was seen in consultation on 11 April 2006. My findings and comments are as follows:

At the present time, Ms. Genereux is a 50 year-old, white woman, who worked at the Raytheon plant in Waltham, MA for 8 years, from July 1982 to November 1990, where she worked with beryllium ceramics in the assembly areas. She indicates that she developed a recurrence of her childhood asthma in about December 1982. She initially consulted with a Dr. "T." of Woonsocket, RI, who told her that she had a "strange kind of asthma, but never evaluated me further". She retired from Raytheon, because after nine years of infertility, she finally became pregnant, which was complicated by bleeding. Therefore, she was placed on bedrest at home by her obstetrician. Her pregnancy was further complicated by bilateral carpal tunnel syndrome, requiring bilateral surgical releases. Unfortunately, the surgery was unsuccessful on the right, so that she could not return to work. She then became pregnant a second time in early 1992 and never was released back to work after delivery, because of continued weakness of her right hand.

She subsequently suffered a probable hypertensive right CVA in 1996, which left her with a severe right hemiparesis, distal right lower extremity greater than proximal weakness, and vascular Parkinson's disease of her right upper extremity. Her initial speech problems did resolve, but she does have a mild residual right facial weakness.

In late 2001, her long-term disability insurance was discontinued by Raytheon. She enlisted the help of Senator Jack Reed, who referred her to the DOL, who recommended that she have a PB LPT, which was positive on 5 February 2002. She was then referred to Dr. Newman at NJH in Denver. Following his evaluation on 27 August 2002, he made a diagnosis of chronic beryllium disease with essentially normal pulmonary function. He recommended a trial of Flovent, which was "complicated by uvular edema". To date, she has not had any other specific therapy for CBD.

Subsequently, she has come under the care of several physicians. Initially, Walter Corrao, M.D., PUD, who placed her on inhalers, made a diagnosis of obstructive sleep apnea (OSA), and doubted the diagnosis of CBD. She then came under the care of Joseph McCormick, M.D., PUD, who discontinued her inhalers, but shortly thereafter moved to New Hampshire. Subsequently, she has been under the care of David Ashley, M.D., her PCP, and more recently, following a November 2005 hospitalization at the Rhode Island Hospital for "respiratory complaints", she has also been under the care of Muhanned Abu-Hijleh, M.D., PUD, who is apparently considering initiating methotrexate (MTX) therapy. She is scheduled to see another OSA specialist in a month, since she has not been able to tolerate a CPAP mask. She has not been seen again by Dr. Newman. Her medical records have been reviewed in detail by Gary Epler, M.D., PUD of the Harvard Medical School, to which Dr. Newman has responded.

Currently, she complains of dyspnea on exertion, when she uses her walker or cane. She becomes winded and lightheaded, which is partially alleviated with nasal oxygen. She also complains of a dry cough, which can occur any time, but especially after exertion and occasionally even at night and which causes urinary incontinence. She denies any chills or fevers, but has persistently complained of severe sweats. Prior to her CVA, she weighed about 185 pounds, but following her CVA gained to a maximum of 248 pounds, more recently weighing about 230 pounds. She complains of anginal chest pain. A dobutamine nuclear cardiac scan suggested anterior myocardial ischemia. She denies any hemoptysis, but does complain of orthopnea, but no PND or ankle edema. There is no history of tuberculosis. A TB skin test was negative about 14 years ago. She has had hypertension for 5+ years, on therapy. She denies any history of atopy. She has documented obstructive sleep apnea, but is unable to tolerate CPAP therapy. She is treated only with nocturnal nasal $O_2$.

Smokes: Never.

Allergies: Penicillin caused an unknown reaction many years ago.

Medications: Nasal oxygen at 2 L per minute during the night and p.r.n. during the day (when she becomes lightheaded), occasional p.r.n. albuterol inhaler, Singulair 10 q.d., Norvasc 5 q.d., lisinopril 20 q.d., Vytorin 1 q.d., Glucotrol XL q.d., Glucophage q.d., and Humulin varying dose p.r.n.

Family history: Her husband was tested for CBD in 2002 also, but was negative. He has not been subsequently retested. She indicates that she is not aware of anyone else from Raytheon that has tested positive. Her father died of congestive heart failure and also suffered from GERD complicated by esophageal strictures.

Social history: She is married with two children, the youngest age 13. She attended a junior college, but did not graduate.

Past medical history:

She is a G4, P2, A2 with C-section X 1. She suffers from insulin-dependent diabetes mellitus, hypothyroidism - euthyroid on replacement therapy, hyperlipidemia with coronary artery disease, hypertension, probable hypertensive CVA with severe right hemiparesis, probable hypertensive cardiovascular disease, vascular Parkinson's on the right, and obstructive sleep apnea.

In reports of 12 September and 15 November 1996, Beverly Walters, M.D., NS, and Joseph Friedman, M.D., neurologist, agree that her right "hemiparesis" was due to a psychological conversion reaction. Dr. Walters also felt that her right upper extremity "Parkinson's" symptoms were also psychosomatic.

Physical examination reveals a well-developed, well-nourished, white woman, appearing about her chronologic age. She is alert, oriented, and in no apparent distress. Vital signs: Normal, including a blood pressure of 170/118. Height: 64 inches. Weight: 223 pounds. BMI is 38.4. Skin and nodes: Negative. HEENT: Negative. Neck: Negative. There are no carotid bruits. Chest: The breath sounds are normal. The expiratory phase is not prolonged. There are no rales, rhonchi, or wheezes, even with forced expiration. Heart: PMI is in the left anterior precordium. There is no gallop or murmur. She does have a resting tachycardia of 90 to 100. Abdomen: Obese. Extremities: No clubbing, phlebitis, or edema. The peripheral pulses are equal and adequate.

Laboratory data: Noncontrast, high resolution, CT scan of the chest is normal. Specifically, there is no radiographic evidence of CBD.

Spirometry of 28 September 1998 is normal, when adjusted for lack of full effort and body habitus.

Complete pulmonary function tests (PFTs) on 29 August 2002 are also normal. Her $O_2$ sat on room air varied between 94-96%, which is normal in Denver.

PFTs of 23 March 2006 are again normal, despite less than full effort and cooperation. PFTs can never be erroneously too high. Thus, we know that she is at the least in the normal range. Lack of reproducibility is irrelevant, when the results are in the normal range. Room air oxygen saturation is normal at 97%. Thus, she does **NOT** and has **NOT** met published criteria for daytime oxygen therapy. CBC is normal. However, her sed rate is high at 36, for unclear reasons. Comprehensive metabolic panel (CMP) is normal. The nondetected serum nicotine and cotinine levels are consistent with her current stated non-smoking status.

Chest x-ray, electrocardiogram, echocardiogram, and arterial blood gases (ABGs) were ordered, but were refused by Ms. Genereux.

Review of prior records:

29 August 2002 - Lee Newman, M.D., PUD - She has a childhood history of asthma.

She has previously been a bird breeder, living with 30 cockatiels in her home for two years. Although she had no apparent symptoms, this exposure could account for the subepithelial bronchial granuloma seen on biopsy.

The bronchoalveolar lavage (BAL) shows a low number of total cells and specifically a low percentage of lymphocytes. I have also reviewed the transbronchial lung biopsy slides, which show only normal thin, delicate alveolar septae. There are no granulomas or any inflammation. There is a single, well formed, noncaseating granuloma in the peribronchial connective tissue. Thus, there is **NO** evidence of a granulomatous pneumonitis, which is the sine qua non for the diagnosis of CBD. Also, there is no bronchial lymphocytosis or eosinophilia.

21 April 2004 - Gary Epler, M.D., PUD - Ms. Genereux has beryllium sensitization, but has no evidence of chronic beryllium disease (CBD) and no evidence of any pulmonary impairment.

Impression:

1. Beryllium sensitization.
2. No evidence of chronic beryllium disease or any other pulmonary or respiratory disease or condition, either caused by or aggravated by her employment with the Raytheon plant in Waltham, MA.
3. Near morbid obesity (BMI - 38.4).
4. Hypertension, unknown cause, poorly controlled despite therapy.
5. Status post probable hypertensive CVA in 1996 with residual severe right hemi paresis, especially of right lower extremity, vascular Parkinson's disease of the right upper extremity, and a mild right facial weakness.
6. Coronary artery disease, complicated by angina pectoris.
7. Obstructive sleep apnea, unable to tolerate CPAP.
8. Bilateral carpal tunnel syndrome, with right residual weakness, status post bilateral surgical release.
9. History of childhood asthma, but no present evidence of airways obstruction or even latent asthma.
10. Possible subclinical pigeon fancier's disease.
11. Probable hysterical conversion reaction, manifested by psychosomatic paralysis of her right lower extremity and a pseudo Parkinson's syndrome of her right upper extremity.

Comments and recommendations: As a result of the above, it is my opinion that Mrs. Genereux is not now and never has suffered from chronic beryllium disease or any other pulmonary or respiratory disease or condition, either caused by or aggravated by her

employment with Raytheon Co. with apparent exposure to respirable beryllium oxide. My reasons for these opinions are as follows:

1. She has no radiographic evidence of CBD. Her CT scan shows no interstitial abnormalities that would be consistent with radiographic CBD.
2. She has no lung biopsy evidence of CBD.
3. She has no PFT evidence of CBD. Her PFTs are well within normal limits, especially when adjusted for inconsistent effort and body habitus.
4. She has no ABG evidence of CBD. She refused ABGs. $O_2$ saturation is 97% - does not need daytime $O_2$.
5. She has no BAL evidence of CBD.
6. Since she has no pulmonary impairment, clearly from a respiratory point of view, she is fully fit to perform her usual work or work of a similar nature in a different industry. Her shortness of breath is due to obesity, deconditioning, hypertensive cardiac disease, and coronary artery disease.
7. She is suffering from a number of other serious and potentially serious diseases and conditions. However, none of these could be fairly attributed to her work at Raytheon Co. with exposure to respirable beryllium oxide particles. Rather, these are diseases and conditions of the general population, which are primarily related to heredity and lifestyle factors.

If there are any further questions, please do not hesitate to write or call.

Sincerely yours,

Lawrence Repsher, M.D.
LHR/bs

William Corrao, M.D.
1285 South County Trail
East Greenwich, RI 02818

Patient: GENEREUX, SUZANNE
DOB: 5/31/1955 Sex: F
Phone: (401) 392-0193
Date of Exam: 4/10/2006
Site: ROUTE TWO

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CT CHEST WO CONTRAST

CLINICAL HISTORY: "Exposure to chemicals". The patient states her illness is due to radiation exposure. Diagnostic codes 994.9 and 786.2.

TECHNIQUE: Non-contrast axial imaging of the chest is performed. There are no prior studies for comparison. After standard imaging, reformatted thin section high resolution imaging was obtained.

FINDINGS: The heart is normal in size. Minimal atherosclerotic calcification is seen in the thoracic aorta. No hilar nor mediastinal adenopathy is seen. No pleural effusions are present. Standard imaging of the lungs demonstrates no evidence of mass nor abnormal interstitial lung markings. Note is made of minimal linear opacities in the extreme inferior lingula which may represent subsegmental atelectasis versus minimal scarring.

Reformatted high resolution images demonstrate no evidence of interstitial lung disease.

Limited visualization of the upper abdomen is unremarkable. Incidental note is made of a splenule, a normal variant.

The visualized bony structures demonstrate degenerative changes within the spine. No lytic or blastic lesions are seen.

IMPRESSION:

CT SCAN OF THE CHEST DEMONSTRATES MINIMAL LINEAR OPACITIES AT THE MOST INFERIOR ANTERIOR ASPECT OF THE LINGULA. THIS IS CONSISTENT WITH EITHER MINIMAL SUBSEGMENTAL ATELECTASIS VERSUS MINIMAL SCARRING. THE REMAINDER OF THE LUNGS ARE NORMAL IN APPEARANCE ON BOTH THE STANDARD IMAGING PROTOCOL AND REFORMATTED THIN SECTION HIGH RESOLUTION IMAGING PROTOCOL. THE REMAINDER OF THE CHEST IS UNREMARKABLE.

LIMITED VISUALIZATION OF THE UPPER ABDOMEN IS UNREMARKABLE.

## Pulmonary Function Laboratory

Rhode Island Hospital, Providence, RI 02903
Tel (401) -444-5307 Fax (401)-444-6545

| | | | | | |
|---|---|---|---|---|---|
| Patient : | GENEREUX, SUZANNE | Height : | 64.0 (in) - 162.6 (cm) | Sex : | F |
| MED REC# | 09193558 | Weight: | 228 (lb) - 103.6 (kg) | BSA : | 2.07 |
| ACCOUNT | 120062294 | Age : | 50 BP: 753 Temp: 28.1 | ATPS | .950 |
| Date : | 03/23/2006 | Calibration Verified : | 03/23/2006 | | |
| Physician : | ABU-HIJLEH | Smoking History : | Non-Smoker Pack/ Years | | |
| Predicted : | Knudson 76 | | | | |

Diagnosis : ABN. CXR
Date of Birth: 5/31/1955
Unit: AMB.
Address: 10 FRY POND RD. WEST GREENWICH, R.I.
Technician: E.REILLY

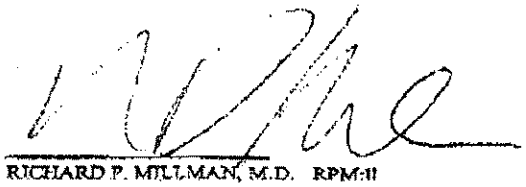
| (BTPS) # Spirometry # | | Predicted | Pre-BronchoDilator Actual | % Predicted |
|---|---|---|---|---|
| FVC | (L) | 3.14 | 3.01 | 96 |
| FEV1 | (L) | 2.55 | 2.19 | 86 |
| FEV1/FVC | (%) | 81 | 73 | 90 |
| PEFR | (L/S) | 5.98 | 3.00 | 50 |
| FEF25-75 | (L/S) | 3.38 | 1.83 | 54 |
| FEF50 | (L/S) | 4.60 | 2.45 | 53 |

| (BTPS) # Lung Volumes # | | Predicted | Pre-BronchoDilator Actual | % Predicted |
|---|---|---|---|---|
| SVC | (L) | 3.14 | 3.01 | 96 |
| IC | (L) | 2.10 | 2.39 | 114 |
| ERV | (L) | 1.04 | 0.62 | 60 |
| RV | (L) | 1.75 | 1.46 | 83 |
| TLC | (L) | 4.89 | 4.47 | 91 |
| RV/TLC | (%) | 36 | 33 | 91 |
| FRC | (L) | 2.79 | 2.08 | 75 |

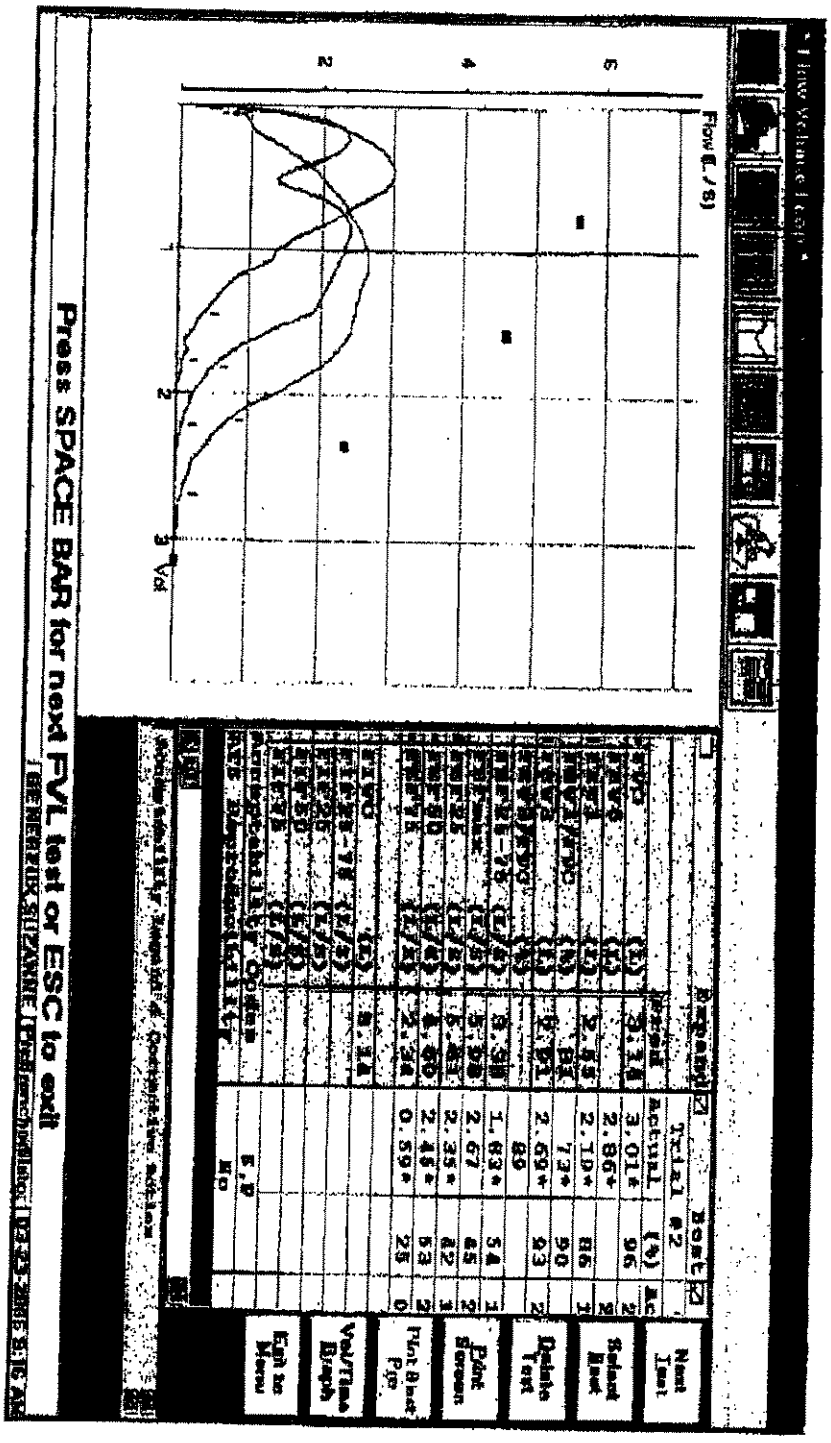
| (BTPS) Diffusion | | Predicted | Pre-BronchoDilator Actual | % Predicted |
|---|---|---|---|---|
| DLco(ml)/min/mmHg | | 22.72 | 17.08 | 75 |
| DLco Corrected | | 22.72 | 17.94 | 79 |
| Hgb | (g/dl) | | 13.00 | |

**Comments:**
NO REPRODUCIBILITY WITH TESTING. NO BRONCHODILATOR GIVEN. O2 SAT = 97% ON ROOM AIR, AP = 120.

**Impression:**
Mild obstructive airways disease is present. Lung volumes show no evidence of a restrictive ventilatory defect. The DLco is within normal limits. Resting oxygen saturation on room air is normal.



RICHARD P. MILLMAN, M.D. RPM:ll


Press SPACE BAR for next FVL test or ESC to exit
Flow (L / S)
Vol
Next Test
Select Best
Delete Test
Print Screen
Plot Best Fvp
Vol/Time Graph
Exit to Menu

**GENEREUX,SUZANNE** F **50 (05/31/1955)** **K61011629** 04/11/06 04/19/06
Phone: (401)392-0193

| Test | Results | Abnormal Results | Normals |
|---|---|---|---|
| Time Since Patient's Last Meal: | 12 HRS. | | |
| Date/Time Specimen Collected: | 04/[illegible]/2006 10:14AM | | |

## Chemistry

| | Test | Results | Abnormal Results | Normals |
|---|---|---|---|---|
| HI | GLUCOSE | 155 | | 70-110 MG/DL |
| | BUN | 18 | | 10-26 MG/DL |
| | CREATININE | 0.7 | | 0.6-1.6 MG/DL |
| | BUN/CREAT RATIO | 25.7 | | |
| | CALCIUM | 9.8 | | 8.3-10.6 MG/DL |
| | TOTAL BILIRUBIN | 0.4 | | 0-1.2 MG/DL |
| | AST (SGOT) | 15 | | 12-45 U/L |
| | ALT (SGPT) | 18 | | 7-40 U/L |
| | ALKALINE PHOSPHATASE | 85 | | 30-115 U/L |
| | TOTAL PROTEIN | 7.3 | | 6.4-8.3 GM/DL |

*NORMALS FOR PATIENTS LYING DOWN COULD BE AS MUCH AS 0.7 GM/DL LOWER.*

| | | | |
|---|---|---|---|
| ALBUMIN | 4.6 | | 3.5-5.0 GM/DL |
| GLOBULIN | 2.7 | | 2.2-4.2 GM/DL |
| A/G RATIO | 1.7 | | |
| SODIUM | 139 | | 135-145 MEQ/L |
| POTASSIUM | 4.1 | | 3.5-5.0 MEQ/L |
| CHLORIDE | 99 | | 98-108 MEQ/L |
| CARBON DIOXIDE | 29 | | 23-33 MEQ/L |
| OSMOLALITY | 282.6 | | 270-290 mOsm/kg |
| NNICOTINE AND METABOLITE | | | |

*NICOTINE: NONE DETECTED NG/ML*
*ANALYSIS BY GAS CHROMATOGRAPHY (GC)*
*OBSERVED CONCENTRATIONS IN HABITUAL SMOKERS:*
*3-63 NG NICOTINE/ML*
*REP. LIMIT 5.0*

*COTININE (NICOTINE METABOLITE): NONE DETECTED NG/ML*
*OBSERVED CONCENTRATIONS IN HABITUAL SMOKERS:*
*20-700 NG COTININE/ML*
*REP. LIMIT 20*

*SPECIMEN TYPE: SERUM OR PLASMA*

*PERFORMED BY:*
*NATIONAL MEDICAL SERVICES*
*3701 WELSH ROAD*
*WILLOW GROVE, PA 19090*



**WILLIAN CORRAO, MD**
**1285 SOUTH COUNTY TRAIL**
**EAST GREENWICH, RI 02818**

*East Side Clinical Laboratory*
*Dedicated service since 1949*
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(401) 455-8400

**GENEREUX,SUZANNE** F 50 (05/31/1955) K61011629 04/11/06 04/19/06
Phone: (401)392-0193

| Test | Results | Abnormal Results | Normals |
|---|---|---|---|
| *Hematology* | | | |
| WBC | 7.3 | | 4.0-10.0 THOUS/uL |
| RBC | 5.02 | | 4.2-5.4 MILLION/uL |
| HEMOGLOBIN | 15.0 | | 12.0-16.0 GM |
| HCT | 44.0 | | 37-47 % |
| MCV | 87.6 | | 80-100 FL |
| MCH | 29.8 | | 27-31 PG/CELL |
| MCHC | 34.0 | | 32-36 %HGB/CELL |
| PLATELET COUNT | 361000 | | 150000-400000 |
| RDW-CV | 13.0 | | 11-15 % |
| HI SEDRATE | | 36 | 1-15 |

*** Released By: EAL,JAM,SKH ***

04/19/2006 10:51AM Final Report

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